Response to Planning and Implementation Resource Manual Public Comments

Section One: PAE

1. The description of the "average" enrollment into the Waiver neglects to mention the key part routinely played by the provider, if they have been identified. Their staff usually does 90% of the "legwork", (see#1-8 and #11). Credit should be given.

The typical PAE process for enrollment into any of the state's HCBS Waivers does not involve DMRS community providers of service since the person is not currently receiving DMRS paid services. DMRS community providers have been involved in this process only for individuals in the process of converting individuals from state funded services into either the Statewide Waiver or the Self-Determination Waiver (conversion) since these individuals are currently receiving services from these DMRS community providers. As this is a temporary situation, it is not covered in this manual.

Section Two: Initial ISP

1. Recommend adding when/why amendments are needed to send to the Plan Reviewers. This is needed because providers are sending amendments in for trivial things and the amount of paper is piling up. Plus, the initial intent was that you would pull the amended page out and then the provider would just replace that page amended, however, when that happens, the page numbers get out of sequence therefore, providers just print a whole new document causing piles of paper and ISPs.
There are examples of when amendments should be completed in the current Provider Manual. The ISP must be current and accurate at all times. This requires that amendments be completed as necessary. It is impossible to complete an exhaustive list of when/why amendments are needed as each ISP must be dealt with on an individual basis.

The ISP format is set up in two ways. The first is set up so that all sections are incorporated into one document and the second is set up so that each section is set up as separate documents. It is the choice of the ISC completing the ISP as to which one to use. Then it is the choice of the provider on how to print out the document and ensure that their files are current. As with any document that is amended, there is no way to ensure the sequencing of page numbers without printing out the entire document.

The overall goal for the current ISP format is that it be developed to cover the full ISP year and lessen the number of amendments required.

2. Page 3, #8 - Having another form completed for Title VI seems unnecessary. The ISCs already document on the Annual Review checklist that they are covering this information with the families. There is nothing in the provider manual that indicates this as a requirement.

The completion of the Title VI form is required. For questions concerning Title VI of the Civil Rights Act of 1964 contact the DMRS Central Office Director of Civil Rights, Brenda Clark.

3. Page 3, number 8 states that the form "Acknowledgement of Receipt of Title VI Notice" should be completed during pre-planning. There is no requirement for this form in the Provider Manual and the completion of this review is documented on the Annual ISP review note. Another form is not needed to document that this information has been reviewed with the individual/legal rep.

The completion of the Title VI form is required. For questions concerning Title VI of the Civil Rights Act of 1964 contact the DMRS Central Office Director of Civil Rights, Brenda Clark.

4. This section needs to be fleshed out to include a description of the intake process, how agencies are notified of potential service recipients, how information is disseminated to various providers, how individuals and their families are assisted in making choices about agencies (for example #19: does the ISC assist the individual and family choose a program by taking them to visit several, or do they must give them the brochures or their own opinion?). This and other sections reference the Risk Management process. It is our understanding that no training has been given to either ISCs or providers how to fold the risk assessment into the ISP. Currently it is either ignored or included in such a way as to increase action steps exponentially, neither approach is helpful. In addition to training, written examples of outcomes and action steps related to common risks would be helpful.

The intake process is not part of the initial ISP, how agencies are notified of potential service recipients, and how information is disseminated to various providers is not part of the development of the initial ISP. These are separate processes conducted by the DMRS Regional Office Case Management Units and would not be covered within this manual. If agencies would like additional information on these processes, they can contact their respective Regional Office Intake Units.

When choosing providers of services, the ISC works with each service recipient on an individual basis and each situation may differ between each individual, each ISC and each ISC agency. The ISC must provide information to the individual and legal representative or family about available providers and the individual, legal representative, and/or family makes the final decision on which to use.

Risk training was provided to Regional Offices and community providers on the following dates. The first date is Regional Office training and the second date is community provider training.
East TN – July 18 and 19, 2005
Middle TN – August 4 and 10, 2005
West TN – July 27 and 28, 2005

The training has recently been updated and Regional Office staff is being retrained. Once regional office staff has received the updated training, they will begin providing this training to community providers at their request. Contact the Regional Office Training Units for information about availability.

Examples of outcomes and actions related to common risks will be referred to the Central Office Training Director for consideration during routine training reviews and revisions. Outcomes and actions for risks should be developed on an individual basis and should be reflective of the person. They should also follow the instructions listed in the "Other Risks…" portion of the Action Plan section of the ISP.

5. There should be at least 2 outcomes, actions, goals for each service provided.

This is a policy decision that must be considered when the Provider Manual is revised. This resource manual can only be reflective of current policy.

Section Three: Assessment
ICAP

1. ISCs/CMs just aren't sure how to integrate ICAP information into the ISP. This may help but still it is difficult. One ISC agency said they were told that at least one action had to address a deficit from the ICAP. The ICAP information should be useful toward the development of the ISP and folks just don't know how to do that at this time.

The ICAP information should be used toward the development of the ISP. At this time, there is no DMRS requirement that actions must address deficits from the ICAP. This may be an internal ISC agency process. The COS and Planning Team should consider the ICAP in the development of the ISP just as any other assessment is considered. This will be referred to the DMRS Central Office Training Director for consideration during the review of the ISC training curriculum.

2. Making sure someone who truly knows the individual best to fill out the form for more accurate information.

This is a requirement of completion and is part of the training. If there are ongoing concerns about specific entities completing the ICAP, this should be referred to the Regional Office Complaints unit or the Regional Office Training unit.

3. The statement "outcomes for acquiring selected skills should be incorporated into the ISP for the providers…to address". In recent state training on ISP outcomes and actions, we were specifically told that the ICAP was not be used in this way. An example of a misuse of the ICAP: an individual was recorded as not being able to read, and thus an outcome was developed to teach her to read. The statement "ICAPs should be completed as often as necessary" is discouraged by current practice. The procedure authorizing the rescoring of new ICAPs is cumbersome. While we have no objection to DMRS' decision to verify changes in ICAP scores, such verification must take place quickly. Requests for revisions in ICAP scores are usually the result of behavioral or health deterioration, and should be granted in a timely fashion.

As discussed in #1 above, ICAP information should be used toward the development of the ISP. At this time, there is no DMRS requirement that actions must address deficits from the ICAP. However, the person, legal representative, Circle of Support or planning team may identify items they want to address as personal outcomes or items that may help to identify other support goals

necessary to ensure the person's health and/or safety or identify barriers that could affect the achievement of outcomes and goals.

Being instructed in "recent state training" not to use the ICAP to assist in the development of outcomes or actions should be directed to the DMRS Central Office Training Director. Specific information about this incident should be related to the above mentioned director.

Completion requirements as listed in the Provider Manual must be followed in order to maintain compliance. Problems with the internal process should be to the DMRS Central Office Director of Operations.

Risk

1. Recommend naming the "one document" – Risk Analysis and Planning Tool. Many providers/ISC/CM do not even know what that form is or that the reviewing and compiling discussion even exists. I think another section may address this. Providers say that the risks are not being discussed at the Planning Meeting.

Revisions to this form would require changes within the current approved Waivers and the Provider Manual. It should be understood that this is one complete document with two distinct sections. Section One, page 1, 2 & 3 is the Risk Issues Identification Tool where risks are identified and explained. Section Two, page 4, is the Risk Analysis and Planning Tool where all identified risks are summarized and decisions about addressing each risk is indicated.

The Provider Manual includes requirements for completing the Risk Issues Identification Tool which includes the Risk Analysis and Planning Tool (page 4). One of the requirements is that the Risk Analysis and Planning Tool be used during the Planning Meeting. If this is an ongoing issue, the Regional Office Agency Teams should be notified.
Trainings have been provided in all regions during July and August of 2005. It is the responsibility of each contracted agency to comply with DMRS requirements. Agencies should contact their respective Regional Office for additional information about Risk training.

Behavior

1. I feel that there should be guidelines on amount of time spent with individual and others before assessment is included. This will allow analyst to get to know the client better and give a more accurate assessment.

This would require a change in current policy and must be addressed when the Provider Manual is revised. This manual can only be reflective of current policy. This information has been forwarded to Dr. George Zukotynski for consideration.

2. Could we consider inserting the word "positive" to precede those times we are writing about "behavioral interventions"?

The terminology used within this resource manual is consistent with the current Provider Manual.

Healthcare Oversight

1. Page 15 indicates who is responsible for completing the health care oversight form. It lists residential first and day providers second. Who would be next on the list to complete them? In this section it goes to families, friends, etc. as the next in line but is this correct? Are PA agencies, therapist or ISCs going to have to complete these for anyone?

Personal Assistance Agencies would be responsible for completing the form if there are no other residential or day services. ISC requirements related to Health Care Oversight are consistent between this resource manual and the Provider Manual. ISCs are not responsible for completing the Health Care Oversight form.

2. The use and usefulness of the Health Care Oversight Form and the Health Passport should be evaluated. What is current?

This resource manual addresses how these forms are used during the planning process for the development of an individual's ISP. The concerns noted in this comment should be directed to Dr. Adadot Hayes at the DMRS Central Office.

Section Four: Pre-Planning

1. Mentions Title VI form to be signed by the person or conservator again – do not feel that this is necessary.

The completion of the Title VI form is required. For questions concerning Title VI of the Civil Rights Act of 1964 you can contact the DMRS Central Office Director of Civil Rights, Brenda Clark.

2. It is difficult to see how (#13) the previous year's ISP can be reviewed (including what worked well and didn't work) without direct conversation with the provider. Similarly it would make sense to include the provider from the front end in discussions (#18) to determine if 1) current services can continue to be provided and 2) provider is willing and able to provide required new services. This would also help in avoiding delay of service later on. Additionally, in most cases provider changes should be preceded by discussions with the current provider as to problems and possible resolution. Again, #26 should include when possible a verification that the identified provider is willing and able to provide the requested services.

There should be regular communication between the Provider and the ISC throughout the year through face to face visits, monthly reviews and meetings (if necessary) that allow for continuous review of how things are working or not working for the person.

Pre-Planning focuses on review with the individual, legal representative and family (Circle of Support). This is a time for the individual and Circle of Support to reflect on what has happened over the past year and to make decisions about the upcoming year based solely on what they feel is needed/wanted without possible undue influence from any provider of service.

This information is again reviewed during the Planning Meeting (as indicated within this manual) with the service providers present so that the service providers can give their input and indicate how and if they can provide the requested services.

Any changes with the planning process would involve policy changes that must be considered when the Provider Manual is revised. This resource manual can only be reflective of current policy.

Discussion about changes with current service providers is left up to the discretion of the individual, legal representative and family.

Section Five: Annual ISP

1. #5 the therapists/BAs are not going to the meetings now to explain and discuss their recommendations. This may be changing. COS/Planning Team are not understanding the need for the service and it is not clear that just because a therapist makes recommendations doesn't mean they all have to be accepted.

Attendance at Planning Meetings for Therapeutic Service Providers and Behavior Services Providers is not currently required within the approved HCBS Waivers. Any changes with these issues would require policy changes and must be addressed when the Provider Manual is revised. This resource manual can only be reflective of current policy.

Therapeutic and Behavioral Services information should be gathered/provided during pre-planning and then finalized during the planning meeting. If there is not clear understanding about the need for services or recommendations, the provider for that particular service should be contacted for further discussion.

There should be ongoing education with all involved parties as to the completion of assessments and what does or does not have to happen once the assessment is completed including the inclusion of any or all recommendations included in the assessments.

2. There should be a deadline by which time agencies will have received the draft ISP: ten days? B7"choose a facilitator": our understanding is that the ISCs role is to be the facilitator. Providers are not averse to taking on this role in certain cases, but doubt that ISCs would consider it appropriate. It does not seem unreasonable to require that cost plans be received by the implementation date of the ISP.

Deadlines for submission of draft ISPs are currently not required. This would require a change in current policy and must be addressed when the Provider Manual is revised. This manual can only be reflective of current policy.

During the Planning Meeting, the individual may choose someone other than the ISC to facilitate the meeting. This can only be done by the individual and cannot be suggested by either the ISC or any service provider.

The authorizing document is the signed Section C. Services and Supports page of the ISP. The cost plan is simply a summary of the approved services for the individual. Turn around time for these documents is determined by the submission date of the plan as well as other factors. Specific time frames for turn around of cost plans by Regional Offices will be considered as this piece of the information system is developed.

3. Therapies need to be paid to attend and travel to meetings.

This is currently not part of the approved HCBS Waivers. This manual can only be reflective of current policy.

Section Six: Behavior Support Planning

1. What kind of changes in a behavior plan will require a new planning meeting and/or changes to the ISP?

The ISP must be current and accurate at all times. If any changes occur in the person's life which makes the ISP inaccurate, it must be changed. This includes changes within the area of behavior supports. The decision about planning meetings must be made on an individual basis by the COS and Planning Team.

Section Seven: ISP Review and Authorization

1. Procedures should clearly describe the provider's responsibilities during the appeals. In particular, service/cost plans should be issued to cover the time period in which the previous year's ISP has been extended.

The appeals process is a separate area that cannot be covered within this resource manual. If additional information is needed in this area, each agency should contact their respective Regional Office Appeals Unit.

Recommendations for changes to the service authorization system would require policy changes and this would be considered when the Provider Manual is revised. This resource manual can only be reflective of current policy.

2. ISC has to send request in 1 week after meeting; this is not enough time to get Dr's orders.

Deadlines for submission of the ISP as indicated within this resource manual and the Provider Manual is 21 days prior to the effective date of the ISP. The submission of a request as mentioned here is not a requirement of the DMRS. It may be an internal ISC Agency policy and if so, needs to be addressed with that particular agency or with the Central Office Director of Therapeutic Services.

Section Eight: Implementation and Documentation

1. Again, examples are needed on appropriate outcomes and action steps.

Examples will be included in the sample ISPs that are currently under development. These will be added as appendices to this resource manual when completed.

2. Therapists should be required to sign in and out of the daily notes rather than DSPs being given the responsibility to record their presence.

Therapists are required to sign in and out. If DSPs are doing this for the therapist, it may be an internal agency policy and should be addressed with that agency.

3. Page 10 numbers 4 and 10 reference the requirement for therapeutic service providers to complete a contact note each time a visit is made with the person. There is no mention of how the information in this contact note is made available to the ISC/Case Manager and direct support staff. It should be clearly stated that these contact notes are to be left in the home record.

These are not required to be left in the home or to be distributed to the ISCs. Therapeutic Services Providers complete monthly reviews that summarize the services provided for the month and the status in relation to ISP actions which would be sent to the ISC.

4. ISCs need to get therapy information in and inform OT when therapy goals and techniques are not approved.

It is unclear what exactly this comment is addressing.
If it is addressing the final decisions made about therapy recommendations made during the Planning Meeting, then… There should be communication between the ISC and any therapist as to the final decisions made during the planning meeting in order for necessary physician orders to be obtained which reflect the final decisions.
If it is addressing approval of services…The signed Section C. Services and Supports section is the authorizing document and is distributed from the Regional Office. There would be communication between the ISC and any therapist to ensure that provision of services occurs.

Section Nine: Monitoring

1. There is currently no system for monitoring ISC's performance of his/her responsibilities in developing and implementing the ISP other than the annual QA survey. Issues tracking system similar to the one the ISC uses on providers must be developed. Clear guidelines must be developed which describe when an ISP must be revised and when a planning team must re-meet. #2 pg. 2, What is the procedure if issues are not resolved informally or at a planning meeting? It is the consensus of ISC/TNCO/ARC workgroup that monthly reviews be changed into quarterly reviews. Not only would this allow enough time for actual progress to be demonstrated, the reviews could be tied to the implementation dates of the ISP and would not then be due all at once.

The development of a system for monitoring ISCs' performance of job responsibilities cannot be addressed within this resource manual. This issue should be directed to the DMRS Central Office Director of Operations.

ISPs must be current and accurate at all times. The plan must be revised when necessary to ensure it is accurate. COS and Planning Team meetings are only required as indicated in the current Provider Manual. Both the revision of the plan and meetings should be based on individual circumstances. They cannot be prescribed as they will differ for everyone. The decisions about revising the plan and meeting is determined by the COS and Planning Team.

The procedure for resolving issues is again based on individual circumstances. If issues are not resolved at the first level, they should be addressed within the agencies' upper management and if necessary Regional Office until resolution is obtained.

Monthly reviews reflect the current HCBS Waivers, Provider Manual, and TennCare requirements. This manual can only be reflective of current policy.

2. A: General Implementation #9 – ISCs are doing their monthly reviews based on provider monthly reviews a month behind. This might delay some notice of issues etc. For instance, the provider is not required to send their monthly review to the ISC until the 20th day of the month but the ISC has to have the monthly reviews completed before that so they would be reporting on the information they received almost 2 months ago.

ISCs are required to do monthly reports as indicated in the Provider Manual and TennCare rules, General Rules, Rule 1200-13-1-.25, (5)(b)1. The monthly review is based on the information they have obtained during the current month for which the review is due.

Appendices

C3: Indicators for Therapeutic Service

1. Training for ISCs in this area would be helpful so that decisions about therapies monitoring could be more informed.

Training is available to all within the DMRS system including individuals, families, legal representatives and advocates. Training concerns should be addressed with the DMRS Central Office Training Director.

C4: Therapeutic Services Plan of Care

1. Encourage the POC be typed or at least legible.

Typed documentation is not required within the current Provider Manual. This issue should be addressed based on specific instances with the therapeutic service provider.

C8: Vocational Evaluation Instructions:

1. How useful are these? Since these are due every 3 years, did everyone need to be evaluated when the new provider manual was adopted?

The requirements for the frequency of completion are maintained in the current Provider Manual. If there are questions about this, it should be referred to the DMRS Director of Operations.

Usefulness should be based on the information contained within the reports and its accuracy. Problems with the information contained within the documents should be addressed with the entity completing the evaluations.

E15: Rates Tip Sheet

1. Therapy rates need to be increased due to increased gas prices and to include meetings.

This is a policy decision that must be considered when the Provider Manual is revised. This resource manual can only be reflective of current policy. This issue should be directed to the Central Office Director of Therapeutic Services.

F1: Documentation Criteria for Res, Day, PA, Respite, Behavioral Respite.

1. Excessive and punitive – Significant changes from original draft which suggested that attendance logs and staff attendance would support billing documentation while daily documentation or minimum required contacts would suffice for programmatic documentation. New wording states "If any are not present, [All Three] funding will be recouped". While we recognize DMRS' prerogative to establish standards, this deviates significantly from the work group's final draft. We would suggest these three support each other, and the presence of any two supports billing, and daily documentation be required to meet programmatic documentation.

Any inconsistencies between the current approved Waivers, the Provider Manual and this resource manual are unintended. We have worked to make sure all three are consistent. However, we cannot include information within this manual that is in "draft" form as they are not current policy and this manual can only be reflective of current policy. Any questions or concerns related to policy issues should be addressed to the responsible unit within the DMRS Central Office.

F2: Monthly Review Process, Res & Day

1. Maybe lengthening the monthly review by adding space for AIMS test, etc. This isn't listed but is vital info for one's health documentation.

The Provider Manual indicates what information is required to be included in the monthly review. Additional information can be included and would be determined by the provider completing the documentation.

I2: Staff Instructions – communication

1. A sample for tracking progress to go along with the communication staff instruction would be helpful to agencies. They struggle with this part.

This should be done in conjunction with therapists, Res/day agencies and developed on an individual basis. General information about this can be obtained from the DMRS Central Office Director of Therapeutic services.